

FILED DEC 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

46609

STATE FILE NUMBER

Registration District No. 312 Primary Registration District No. 541 Registrar's No. 2928

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u>		c. CITY OR TOWN <u>Jennings</u> <u>4148</u>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>		d. STREET ADDRESS <u>5823 Janet Ave.</u>	
Length of stay in lb <u>7 days</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>AGNES</u>		4. DATE OF DEATH <u>11 23 1957</u>	
First <u>AGNES</u> Middle <u>MURPHY</u> Last <u>MURPHY</u>		Month <u>11</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 23 1893</u>
9. AGE (In years last birthday) <u>64</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>	
11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Byran King</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Elizabeth Hobold</u>		Address <u>5823 Janet Ave.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>465X</u>		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>a. m.</u> Month, Day, Year	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
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21. I attended the deceased from <u>11-18-1957</u> to <u>11-23-1957</u> and last saw <u>her</u> alive on <u>11-23-1957</u> Death occurred at <u>902p</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Robert J. Lane M.D.</u>	22b. ADDRESS <u>601 S. BRENTWOOD BLVD.</u>	22c. DATE SIGNED <u>11/25/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>11/27/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Buchholz Mortuary 5967 W. Florissant</u>	25. DATE RECD. BY LOCAL REG. <u>11-26-57</u>	26. REGISTRAR'S SIGNATURE <u>Robert B. Donohue M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

Public Health Service

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by _____, Student Embalmer No. _____
working under my personal supervision..

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 45

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (It
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.